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ABSTRACT

In 1973, the Head Start Division of the Administration for Children, Youth and Families (ACYF) initiated a Child and Family Resource Program (CFRP) demonstration. As part of Head Start, CFRP had as its primary goal enhancing children's development. The demonstration was designed to develop models for service delivery that could be adapted by different communities to serve different populations. CFRP operated in 11 sites, with each program receiving approximately 178,000 to 199,000 dollars per year to serve from 80 to 100 low-income families. In October of 1977, a longitudinal evaluation was initiated by ACYF in five sites. The evaluation employed an experimental design supplemented by descriptive and qualitative methods and focused primarily on CFRP's Infant-Toddler Component, the portion of the program serving children from birth or the prenatal period until 3 years of age. This report summarizes the operation and effects of the Infant-Toddler Component. Chapter 1 provides a close-up portrait of CFRP in operation, while chapter 2 deals with the effects and effectiveness of CFRP. The third and final chapter draws implications for policy and program management. The design of the CFRP evaluation, study components, measures, and statistical methods employed are described in an appendix. (RH)

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HEAD START RESEARCH PROGRAM EVALUATION

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THE EFFECTS OF A SOCIAL PROGRAM:

EXECUTIVE SUMMARY OF CFRP's INFANT-TODDLER COMPONENT

Fall 1982

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THE EFFECTS OF A SOCIAL PROGRAM: EXECUTIVE SUMMARY OF CFRP'S INFANT-TODDLER COMPONENT

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FOREWORD

In 1973, the Head Start Division of the Administration for Children, Youth and Families (ACYF) initiated the Child and Family Resource Program (CFRP) demonstration.* As part of Head Start, CFRP had as its primary goal enhancing children's development. However, the program represented an innovation within Head Start in four important respects:

- its emphasis on helping the child through the family;
- its focus on developmental continuity through the early stages of the child's growth;
- its comprehensive approach to family services; and
- its development of individualized plans for services to be obtained through CFRP, based on assessments of each family's strengths and needs.

The demonstration was designed to develop models for service delivery, which can be adapted by different communities serving different populations. CFRP operated in eleven sites, with each program receiving approximately $178,000-$199,000 per year to serve from 80 to 100 low-income families. The CFRP demonstration is scheduled to conclude in fall 1983. All programs are seeking local, state or federal funding to ensure continued provision of family-oriented child development services in their respective communities.

In October 1977, a longitudinal evaluation was initiated by ACYF in five sites. The evaluation employed an experimental design (involving

*CFRP was a direct outgrowth of the 1970 White House Conference on Children. Conference recommendations called for (a) redirecting delivery systems "to provide services and support through and to the family as a unit with recognition of the different needs, strengths, and weaknesses"; (b) reordering "existing services and programs to fit around desires and aspirations of families"; and (c) establishing Neighborhood Family Centers to "eliminate fragmentation of services." The CFRP demonstration incorporated many of these recommendations in a child development context.

random assignment to a program or control group), supplemented by descriptive and qualitative methods. It focused primarily on CFRP's Infant-Toddler Component, the portion of the program serving children from birth or the prenatal period until age three. This report summarizes the operation and effects of the Infant-Toddler Component.

Although CFRP will cease to exist as a separate entity, the CFRP experience contains lessons for future programs with similar goals. We hope that this report, together with earlier study documents on which it draws (see Appendix A), will provide a useful public record of that experience. The federal climate surrounding social service programs has changed dramatically since CFRP and its evaluation began. Nevertheless, programs for children and families will continue to exist, whether under private, local, state or federal auspices. Such programs can potentially learn from CFRP's attempt to broaden the scope of child development services, to support families and to coordinate the efforts of multiple agencies serving low-income populations.

The findings are summarized in three chapters. Chapter 1 provides a close-up portrait of CFRP in operation. Chapter 2 deals with the effects and effectiveness of CFRP. Chapter 3 draws implications for policy and program management. The design of the CFRP evaluation, study components, measures, and statistical methods employed are described in Appendix B.

We appreciate the hard work of the many people who together have made this study a success. Several deserve special recognition for their contributions of time and ideas to the evaluation effort. Appendix C lists major contributors to this five-year study.

Marrit J. Nauta
Project Director
September 1982

CHAPTER 1

A CLOSE-UP PORTRAIT OF CFRP: PROGRAM OPERATIONS AND MODELS

The Child and Family Resource Program (CFRP) shared many features with other child development programs, including Head Start itself, other Head Start demonstrations, such as the Parent-Child Centers and the Parent-Child Development Centers, and privately funded programs, such as the Brookline Early Education Project. What made CFRP unique was the way in which it combined these features. Four elements characterized the CFRP approach:

Emphasis on the Family. While CFRP provided some services directly to children, such as early education and health care, the program stressed helping the child through the family. Abundant research had shown that the child's social environment--principally the family during the early years--is the primary source and support for development. Consequently CFRP provided parent education and parent counseling in matters related to childrearing, as well as more general family support services.

Developmental Continuity. Whereas most child development programs serve children in a fairly narrow age range (e.g., the preschool period), CFRP recognized the importance of continuous support through the early years. It recruited pregnant women and mothers with young infants and provided services until the child reached age eight, well into elementary school.

Comprehensive Services. Recognizing that the family's ability to foster child development depends on its own cohesiveness, economic security and social ties, CFRP attempted to marshal a wide range of support services, addressing in some fashion virtually every need of low-income households. Some of these services were provided directly; for example, many programs provided counseling about jobs, education, housing and personal finances. However, due to the magnitude of the families' needs and CFRP's fiscal limitations, most support services were provided through referrals and coordination of other community agencies and organizations.

By dealing with the full range of each family's needs, CFRP attempted to bring some degree of coherence to the fragmented system of public and private social services with which low-income families typically must deal.

Individualization. CFRP also recognized that each family is unique, despite the common problems that low-income families face. Accordingly, the program engaged in both formal and informal processes of needs assessment and goal-setting, in an effort to tailor services to the needs of each individual family and to build on the family's strengths. Thus different families received different services. Each family experienced CFRP in its own way.

CFRP services were offered within the context of three program components--the Infant-Toddler Component, Head Start and the Preschool-School Linkage Component. Each was intended to serve families with children in a specific age group. All three taken together were intended to provide developmental and educational continuity across the period of the child's life from before birth to the primary grades in school.

The Infant-Toddler Component served families with children from birth to age three. Two main types of program activities were offered to families with children in this age range--home visits and center sessions. (In addition, special services such as crisis intervention, counseling, assistance with personal and financial problems and the like were offered on an as-needed basis.) Home visits, conducted by family workers, were used for needs assessment and goal-setting, parent education and counseling, and child development activities. Center sessions were generally of two types: parent education sessions, in which parents heard lectures and discussed common problems, and infant-toddler sessions, designed to provide children with a group experience and, in some sites, with educational or even therapeutic experiences.

Head Start served families with children from approximately age three until they entered school. During this period children received developmental services through Head Start itself. Parents continued to

receive home visits, to attend center sessions and to receive other support services from CFRP, although the intensity of services varied across sites and in many cases diminished when children entered Head Start. As Head Start took over the child development function, CFRP tended to concentrate on other family needs. This tendency was especially pronounced in some sites, where CFRP was viewed as the social service component of Head Start rather than as a child development program in itself.

The Preschool-School Linkage Component was the least clearly defined and least developed of CFRP's three components. All CFRPs established links with public schools, but the linkage system was generally limited to establishing contact, finding out about registration procedures and informing schools that CFRP children would enter. Some transitional services were provided. These included orientation of Head Start children, their parents and school personnel; troubleshooting in response to requests from parents and school personnel; and tutoring of children either by CFRP staff or by referral to community tutorial services. Other common services included sharing children's records with the schools and assisting in placing children with special needs. Some programs continued to make home visits after children entered school; however, visits were less frequent and less comprehensive than previously. Other programs made visits only in response to school-related problems. No center sessions were conducted specifically for parents of school-age children except in one site. Comprehensive followup on school-age children was not possible because of resource limitations.

A final important element of the CFRP approach was local variation and innovation. ACYF encouraged programs to adapt to the needs and resources of their communities. As a result, CFRP was "invented 11 times." Despite common goals and common organizational features, the 11 sites differed markedly in the populations they served and the particular ways they chose to deliver services. These striking site differences make generalizations about CFRP as a whole rather risky.

The remainder of this chapter summarizes our findings about the operations of CFRP in the form of a series of answers to key questions about the program, particularly its Infant-Toddler Component (the main focus of the evaluation). The chapter also identifies "models," or aspects of program operations that could be replicated in other communities.

1.1 Organization and Staffing

How were CFRP and Head Start linked?

Close linkage between CFRP and Head Start was implicit in the program's Guidelines; Head Start was one of the three major activities offered to families enrolled in CFRP. In practice there was considerable variation across programs in the strength of the CFRP-Head Start linkage. At some sites, the programs were fully integrated, as the name of one such program, "Family Head Start," suggests. In other sites, CFRP and Head Start were linked organizationally but operated to a large extent as separate entities. At still other sites, CFRP and Head Start were virtually independent programs.

There were three major benefits associated with full integration of CFRP and Head Start:

- Smooth transition from one developmental stage to the next. Enrollment of children in Head Start was significantly higher in integrated sites.

- Greater continuity of services to the family. There was more collaboration between workers serving different age groups of children than in sites where linkage between the two programs was not as strong.

- A richness of staff resources, with several people providing specialized services to families and children. Such pooling of resources between the two programs occurred to a lesser extent in sites where CFRP and Head Start were not fully integrated.

How were CFRPs staffed?

Programs typically had 10 to 20 full- and part-time staff members. At each site there were four to six family workers--called home visitors or family advocates--each with a caseload of about 20 families. Nearly all family workers were women, most of them mothers. Family workers were the vital link between CFRP and the families it served; they were responsible for assessing child and family needs and strengths, helping families set goals and obtain services, and conducting regular visits to homes. In some sites, they organized center activities for parents and children as well. They were teachers of children, educators of parents, social workers, counselors, and friends. As one family worker aptly put it, they were "supposed to be everything to everybody, any place, and any time."

The remainder of the staff were administrators and specialists. Overall there was a strong representation of social service backgrounds on the staff and a relative lack of child development expertise, which strongly influenced local program orientation. However, there was also considerable variation across sites in the number of specialized staff available and in the degree of child development expertise represented on the staff. As noted earlier, sites with close links between CFRP and Head Start were rich in staff resources. One of these programs included among its specialists an education coordinator, a parent trainer, a consultant for the handicapped, a child care coordinator, a health coordinator, a mental health consultant, a nutrition consultant, and a special services advocate. In contrast, one of the programs in which CFRP was operated as a separate entity had a staff of only three administrators/specialists--a director, a home visitor supervisor, and an infant-toddler specialist responsible for group activities.

What were the qualifications of family workers?

There was considerable variation in the level of education of family workers--from high school graduates with a few college credits to college graduates with additional training. According to local CFRP directors, professional credentials were considered to be of secondary importance

in recruiting family workers; recruitment was guided by the philosophy that a college degree did not necessarily qualify an applicant for a staff position, and none of the programs chose a specific discipline as a prerequisite for family worker positions. Personal and job-related experience were considered at least as important as formal training. Programs felt that staff who had demonstrated their competence in practical ways would often be more readily accepted and in the long run more effective at the grass-roots level than people with a theoretical background but little or no experience with the problems faced on the job. Some programs actively recruited indigenous paraprofessionals, especially former CFRP mothers, in an effort to maximize rapport and provide jobs and upward mobility. In sum, personal and affective characteristics--sensitivity, maturity, and compatibility of background with the families served--were of primary importance. The ability to build relationships of trust and support with families served was seen as the key to effective service delivery.

How were family workers trained and supervised?

The recruitment of paraprofessionals for positions as family workers lends urgency to the issue of training and supervision. Previous experience with home-based programs in Head Start showed that paraprofessionals can deliver effective developmental services, but only when supported with intensive training and supervision.*

All family workers at each site, regardless of academic credentials or previous experience, were required to complete the same pre- and in-service training. The amount of training provided varied considerably across the sites, however. Although an impressive array of topics was addressed in in-service training, it is difficult to assess what topics received the most emphasis, the quality of the training sessions, or the extent to which they met the needs of family workers.

*Love, J.M. et al. National Home Start Evaluation Final Report-- Findings and Implications. High/Scope Educational Research Foundation and Abt Associates Inc., 1976.

In CFRP there was generally not a great deal of supervision of family workers in the field at any site. Some family worker supervisors simply believed that this kind of work cannot be supervised by "standing over" the workers. The method of supervision used most frequently was review of records and progress notes on individual families. In some sites, family workers met regularly with their supervisors, but informal supervision--through staff meetings or conversations--was more typical. Where supervision was routinized through paperwork--approvals, reports, sign-offs--it sometimes appeared pro forma.

Supervisory staff did provide support to their family workers in other ways. They were available for consultations when family workers were experiencing problems or were uncertain about how to handle particular family situations--for example, a family in which the children seemed depressed or otherwise disturbed but showed no apparent signs of neglect or abuse. Occasionally, supervisory staff accompanied family workers on home visits to provide assistance with particularly difficult problems.

1.2 Program Services

How were services individualized?

A distinctive feature of CFRP was its effort to tailor services to families' needs. This individualization was perhaps most visible in the realm of social services, but the same principle was applied to child development and parent education activities. There was general agreement across sites about the theory of individualization. Needs assessment was seen as the key to individualization--the means by which services were tailored to families. According to one staff member, "assessment was the heart of CFRP." Staff saw this as a special feature of CFRP. One family worker said, "Other agencies don't always understand that you can't force a plan on people. . . . CFRP always works from the perspective of the family." And parents agreed: "They asked me what I wanted."

Formal needs assessments were conducted when a family entered the program and at intervals of six months to two years thereafter. At each

reassessment, needs were determined, new goals were set, and old goals were reviewed for progress. There was wide variation across sites in the conduct of both initial assessments and reassessments, and individualization was not always accomplished through the formal needs assessment procedures. There were, for example, instances of a lack of staff commitment to the formal procedures; in other cases, the assessment procedures seemed somewhat mechanical.

Yet even where the formal procedure was less effective than it might have been, individualization of services did occur through the efforts of the family workers, who appeared uniformly committed to getting families the services they needed. And for many families, the setting of goals--the most visible part of needs assessment--was of great help in giving them a feeling of progress.

Two different approaches were used in assessing family needs. In most sites, an assessment team--usually family workers and supervisory or support staff--met to review needs data which had been gathered by the family worker. In several CFRPs these team meetings also included staff members from other community agencies, when appropriate. The assessment meeting was the basis for making a family action plan: establishing specific family goals, and determining who would take what steps, and when, to achieve those goals. In a few sites, no formal assessment meeting took place; rather, it was the responsibility of the family worker to complete an assessment form with the family and to develop a plan for the provision of services.

In both cases, the family action plan was the product of mutual agreement between the parents and family workers. Some programs required that parents be present at the formal assessment meeting; at other sites they were allowed or encouraged but not required to attend. In reality, where attendance was optional, parents usually did not attend and when they did, discussion was stilted and took only about half as long as it did when parents were not present. Some staff felt it would be "too intimidating and too clinical" for parents to be present.

In sum, despite some shortcomings of the formal assessment procedures, one of CFRP's strongest points, at every site studied, was its largely successful attempt to respond to individual family concerns and needs.

What social services were provided to CFRP families?

Although CFRP's ultimate goal was fostering child development, its chosen means for achieving this goal were to strengthen families and educate parents. CFRP staff recognized that conditions of need may inhibit parenting skills by distracting parents, preventing them from "attending to child development." Thus it was frequently necessary for the program to intervene and assist in meeting basic needs before staff could turn to parenting or child development concerns. Provision of social services was therefore a major focus of CFRP.

There was some variation from site to site in the mix of social services provided directly and by way of referrals. The differences reflect local availability of resources to meet family needs, as well as the particular strengths of the local CFRP. More social services were provided directly in programs rich in staff resources than in other sites, which had to rely almost entirely on referrals to social service agencies. Resource-rich programs had more staff time and expertise to establish and maintain links with social service agencies, making referrals and doing follow-up work. The other programs assigned primary responsibility for developing networks and making referrals to individual family workers with varying amounts of support provided by supervisory staff or specialists. Thus, where staff resources were rich (and links between CFRP and Head Start strong), CFRP's effectiveness in providing social services was enhanced.

Staff from nearly every program listed counseling among the services they provided directly to parents. This counseling ranged from a sympathetic "listening ear" during home visits to professional clinical help. The majority of the programs also offered health and nutrition screening and immunizations, and several offered various types of treatment, such as speech therapy or the services of a dental hygienist. These services were often

provided by people outside the CFRP, who were paid by the program or donated their time and work. Other direct services mentioned by staff included job counseling, legal advice, and recreational opportunities. In some cases, services were not provided at the program, but were paid for by CFRP, such as emergency health care or food and clothing.

Staff made parents aware of their eligibility for public assistance and helped them apply for Aid for Dependent Children, food stamps, Medicaid, or other entitlements. They helped families negotiate their way through the welfare system; for example, when AFDC checks or food stamps were stolen, lost or delayed, CFRP staff often vouched for the legitimacy of these claims. Occasionally arrangements were made for emergency financial aid to buy food, or pay heating, utility or housing bills. Staff assisted parents in obtaining adjustments or postponements of charges from public utility or telephone companies, or emergency medical services free of charge. The list of services available or obtained by families through CFRP was almost endless. Whether the need was for transportation, translation, housing, child care, legal aid, or shelter for victims of domestic violence, staff ingenuity and determination were applied to resolve the problem and get needed help.

CFRP attempted to give families one place where they could turn for help with a variety of problems and to reduce fragmentation of community services. The program served as a broker between families and the rest of the social service system, putting families in touch with appropriate agencies and helping them acquire services. Provision of social services was a strength at every site studied.

What developmental activities were offered in the Infant-Toddler Component?

A view of the parent as the primary educator of the child was an integral part of the CFRP mandate. It was through working with the parent, rather than working with the child in isolation from the family, that the program expected to enhance the child's growth and development.

Infant-toddler services were provided to families in the context of home visits and center-based activities. Home visits were a key point of connection between families and CFRP. They were a source of continuity in each family's relationship with the program and the vehicle through which many of the program's services were provided. In particular, they were the locus of many of the program's activities in parent education and child development. However, they varied widely in frequency and focus from site to site and in many instances did not constitute an adequate basis for a sustained child development program.

The intensity of child development activities was limited by the fact that home visits were not devoted exclusively to such activities. Roughly half, and in many cases more than half, of each visit was devoted to other family needs. Home visitors spent substantial time in offering advice and monitoring progress regarding family goals in education, employment, housing, budgeting and securing financial aid. Crises were common, and when they occurred, parent education and activities with children took a back seat. As one family worker commented: "It's difficult to tell parents that your child should be at this or that stage of development when they're worried about having enough money to pay the rent or buy food." Family workers had to deal with these problems, giving practical help where possible and always offering a sympathetic ear, in order to maintain the rapport that was so essential to their functioning. The price paid in foregone developmental activities was nevertheless significant.

Except in one site where the child development and social service functions were split between two family workers, the two functions were mixed in every home visit. However, the balance between the two and the quality of the developmental activities that were provided was extremely variable. At every site there were some examples of skillful work during home visits. However, there were also examples of didactic, mechanical use of predetermined exercises, with little attempt to capitalize on the interest of the child or the mother, and in some cases with little apparent comprehension of the purpose of the exercise.

Some sites based their infant-toddler curricula on sources such as the Portage Guide. Other sites devised their own approaches and compiled materials from various sources. None of the programs attempted to implement or adapt any of the intensive, experimental infant-toddler curricula that currently exist and were used, for example, in the Parent-Child Development Centers. There was no obvious relationship between the degree of curricular structure in the child development activities offered at a particular site and the apparent quality of these activities.

Center activities were, along with home visits, vehicles for providing parent education and child development services. Like home visits, center sessions combined these functions with other family concerns and needs. In most programs, separate center activities were held for parents and children. Although several sites planned social activities involving both parents and children, only one CFRP regularly had parents work directly with their children under the supervision of a child development expert.

Parent sessions covered a wide variety of issues. Some dealt explicitly with child development and/or parenting. Others focused on psychological and social problems of parents, home management and other topics of general concern. Some were largely social and recreational.

Center sessions for children included classroom experiences and supervised play. On the whole, however, center sessions were not used as the focus of intensive developmental work with children. At some sites, children's center sessions were largely a convenience for parents--child care provided to enable parents to participate in center activities.

In sum, although CFRP provided a variety of parent education and child development services, these were not of uniformly high quality and intensity. Family workers were often too busy dealing with families in crisis to spend time with those for whom parent education and child development activities were most likely to be welcome and effective. Even where crises were absent, parent education and child development often was secondary to family support.

How frequently did families participate in infant-toddler activities?

Home visits to families in the five sites studied occurred once a month on average, although the scheduled frequency was much higher. Cancellations and postponements were common. The observed (and scheduled) frequency of home visits was significantly lower than that needed to provide an effective child development program in the home, according to findings based on previous Head Start demonstrations. Results of the Home Start evaluation, cited earlier, showed that a minimum of one hour-long visit per week is required to produce any measurable effect on children. The low frequency of home visits was undoubtedly linked to high family caseloads: family workers typically had caseloads of 20 or more, whereas the Home Start study indicated that a caseload of 13 was the maximum feasible in order to maintain an adequate frequency of visits.

Parent participation in center activities was even more problematic. Almost half of the families attended center sessions only sporadically--once per year on average. Regular participants, on the other hand, participated in at least one session per month. The problems of nonparticipation were more severe in some of the CFRPs than in others.

Furthermore, programs experienced a relatively high dropout rate. Of the families studied, only half completed the three-year Infant-Toddler Component.

CHAPTER 2

THE IMPACT OF CFRP

As noted in Chapter 1, CFRP was premised on the belief that child development is best fostered within a secure family environment. A major focus of the program was to improve family functioning, which in turn was expected to mediate child development and other outcomes. This chapter examines the impact of CFRP on children and families from that vantage point. Section 2.1 addresses CFRP's effects in the areas of family functioning and family circumstances. Next we focus on the program's impact on parental teaching skills and child development--the primary goal of CFRP (Section 2.2). The concluding section (2.3) identifies families for whom CFRP was most effective and factors that contributed to overall program effectiveness. Findings, obtained at several time points, are summarized as answers to a set of key questions.

2.1 Family Functioning and Circumstances

Improvement of the family's concrete circumstances--employment, education, income, housing and the like--was not formally a part of CFRP's mandate. However, as noted above local staff recognized that meeting these pressing needs was often necessary in order to strengthen the family internally and to create an atmosphere in which the family would be receptive to education in child development. The program therefore engaged in extensive counseling and referral to put families in touch with existing resources relevant to their economic needs. In addition staff worked with families to improve their skills in securing services for themselves and to increase their confidence and ability to cope with pressures and problems. These efforts were successful in several respects.

Did CFRP improve families' prospects for economic self-sufficiency?

YES. During the study's three-year data collection period there was a dramatic increase in the proportion of CFRP mothers who were employed and/or in school or job training. (There was also a substantial increase

among control mothers, but the increase for CFRP was larger.)* Qualitative evidence showed that some CFRPs actively encouraged mothers to work and helped them to find jobs or enroll in school or vocational training programs. On the other hand, as discussed in more detail below, the evidence also showed that CFRPs were not particularly flexible in adapting to the schedules of working mothers; hence program participation suffered when mothers got jobs. For this reason some CFRPs were neutral toward, or even discouraged, work. As a result there were large site differences in the magnitude of CFRP's effect on employment/training, and in one site the effect was negative.

During the three-year data collection period CFRP and control families both reported an increase in reliance on wages and a corresponding decrease in reliance on welfare and other sources of public support. However, in this case the increase was slightly smaller for CFRP families than for control families. To a large extent this finding is attributable to the single site where employment decreased among CFRP mothers. It may also be due to the fact that CFRP increased the use of community services at most sites, at the same time that it helped mothers to find employment (see below).

Did CFRP improve access to community services?

YES. After 18 months in CFRP there was evidence that access to services had improved for CFRP participants. Parents reported increased knowledge of resources in the community and greater ease in obtaining services. After both 18 months and three years, there was also evidence that participation in CFRP had led to increased utilization of community resources. CFRP increased the range of public assistance programs (AFDC, food stamps, Medicaid, WIC) used by participating families. Qualitative data illustrate, however, that the program's assistance was not limited to helping families to secure particular forms of public assistance. As noted earlier, short-term assistance was provided with a wide range of special problems, such as

*All quantitative findings reported in this chapter were statistically significant ($p<.05$) or marginally significant ($p<.15$).

lost or stolen welfare checks, disputes over rent or phone bills, emergency needs for extra money for food, medicine or even furniture, and referrals for health care, housing, day care, job training, and employment.

CFRP's impact in improving access to community services is perhaps best summarized by the following three comments:

> CFRP is an ombudsman for people who don't have a voice; it is a program that takes advantage of available resources in the community and in turn makes them available to families.
>
> --a representative of a social service agency

> CFRP helps families to feel they're part of a community, that they can go to an agency--they have a right, the agency is there for them.
>
> --a CFRP director

> CFRP is my ace in the hole
>
> --a CFRP participant

At several sites the benefits of CFRP went beyond the client population and had a broader impact on the community at large. CFRP staff were strong advocates for change to ensure that resources were made available to low-income families, not only those enrolled in CFRP.

Did CFRP improve preventive health care for children or families?

YES, but only to a very modest degree. At the end of the Infant-Toddler Component, CFRP children were a little more likely than controls to have had medical checkups in the past year. No other measure of preventive health care--dental care for children or mothers, family health insurance or absence of problems in obtaining health services--differed between CFRP and control groups. This finding was initially somewhat puzzling, because qualitative evidence made it clear that CFRP staff devoted considerable effort to securing health services for participating families. The finding may be explained by the fact that control families placed a high priority on health

and made special efforts to secure health services. Evidence of this conjecture can be seen in the fact that both CFRP and control groups were well-served, according to several measures (very high proportions of children receiving medical checkups and of families having health insurance, and very low proportions of families reporting difficulty in obtaining health services); consequently there was little room for CFRP to show an advantage.

Did CFRP increase families' independence?

NO. There is no evidence to suggest that CFRP made participants more independent in securing social services. On the other hand, the program did avoid the negative effect of increasing dependence. Critics of social programs such as CFRP often argue that they cause dependence on government and undermine informal social support networks such as the extended family. Early findings (after 18 months) suggested that--to some degree, at least--the program was replacing informal support networks; CFRP families tended to rely more on CFRP and other agencies for help in finding services, whereas families in the control group relied more on relatives and friends. This appears to have been a short-term effect, as CFRP staff initially made families aware of available services and encouraged their use. After three years, there were no differences between CFRP and control families in their reliance on friends, family, private sources of support and on themselves, as opposed to reliance on government agencies.

Did CFRP strengthen parental coping skills?

YES. Perhaps the most important finding to emerge in the area of family functioning was that CFRP increased parents' feelings of efficacy. After three years in the program, CFRP parents scored significantly higher than control parents on a "coping" scale, i.e. one that measured "internal locus of control," or ability to control events. CFRP parents also showed a more positive change in feelings of efficacy than did controls during the study's three-year data collection period.

Qualitative reports contain a wealth of information confirming the intangible but crucial shifts in attitude that took place in parents who were often badly demoralized at the start. In addition the qualitative data showed that these attitudinal changes were often accompanied by striking changes in behavior. One single mother with three children who was almost totally withdrawn at entry into CFRP became a community activist. CFRP "showed me I could do something other than housework, watching soap operas, and chasing kids, that I could be independent, that I could take care of myself." In another site, a family worker proudly describes the "astounding progress" made by one mother:

> Three years ago [Sally] was living in a run-down apartment house. Her relationship with her children was very poor. She was taking so much nerve medicine that she had a very low response level. She did not take care of herself or her children very well, and she felt isolated from any type of social contact and stayed much of the time at home.
>
> Today, Sally has a job, has lost several pounds and looks good. She has bought her own home and takes pride in decorating it. She discusses her children's progress in school with good humor and much pride. Her eyes are clear and alert, and she rarely takes any nerve medication.

2.2 Parental Teaching Skills and Child Development

As detailed earlier, CFRP had a dual strategy for achieving its ultimate goal of enhanced child development: (1) strengthening families by providing social services; and (2) training parents to be more aware of their role as educators and more skillful in stimulating children's social and cognitive growth. CFRP's approach implied that attention would shift from social service provision to parent education and child development, once families had learned to cope adequately with financial and personal problems. This approach was only partially successful.

Did CFRP increase parental awareness of their role as educators of their own children?

YES. CFRP's activities in parent education led to significant changes in parents and promoted childrearing practices associated with positive social and cognitive development of children.

After three years in the program, CFRP parents scored higher than parents in the control group in three of five domains of Strom's Parent-as-a-Teacher (PAAT) Inventory (a self-report measure). CFRP mothers expressed less frustration with potentially irritating aspects of children's behavior and greater willingness to give children freedom to make choices than mothers in the control group.

An earlier small-scale observational study conducted at two sites provides additional confirmation that CFRP had a positive impact on parental teaching skills. After 18 months in the program, a carefully selected sample of high-participating CFRP mothers, observed in their homes using the Carew Toddler and Infant Experiences System (TIES), interacted more with their children and devoted more of their interaction to teaching, especially of language mastery skills, than a closely matched group of mothers from the control group. In addition, qualitative data highlight many cases of increased insight and change in parental attitudes and practice.

Was CFRP effective for children?

NO. CFRP had no significant overall impact on the social and cognitive development of children. Results of Bayley Scales of Infant Development assessments conducted after approximately 18 months in the program showed no differences between the CFRP and control group. Developmental assessments after three years of participation in CFRP, using various scales of social and cognitive growth--the 32-item Preschool Inventory (PSI), the High/Scope Pupil Observation Checklist (POCL), and the Schaefer

Behavior Inventory (SBI)--produced similarly disappointing results.*

Thus the significant changes in parental attitudes and practices did not translate into immediately measurable benefits for children. This lack of developmental effects may be explained by a combination of factors. Program activities did not occur with sufficient frequency to provide effective child development services and family participation was problematic even for families who participated actively; much of the program's effort was devoted to family support rather than child development activities per se. The activities that did occur relied too heavily on discussion and made insufficient use of modeling and hands-on practice, so that it may have been difficult for parents to know how to translate their insights into action. Also, some of the activities were unsystematic, poorly conceived or poorly understood by family workers.

It is possible that CFRP's effects are "sleepers," which will manifest themselves much later in the child's development, as effects of some early intervention programs reportedly have done. It is also possible that the observed changes in parents' childrearing attitudes and practices will have later effects on younger siblings of CFRP children. However, the fact remains that, even after a three-year period, the program failed to affect a number of measures that have been influenced significantly by other intervention programs.

Did CFRP enhance children's physical growth?

NO, for children in the study sample. No differences were evident between the CFRP and control group on height and weight measures. The absence of effects on physical growth is not surprising, since these are usually found only for programs providing nutrition and health services to severely malnourished children. Children at risk had been excluded from the

*The children in the CFRP evaluation sample were younger than those tested in previous studies. The sample as a whole was at the lower end of the age range for which the PSI is appropriate. The absence of PSI results may be due partly to floor effects.

study sample because it would not have been ethical to assign such children to the control group, preventing them from receiving services.

Was CFRP effective in enrolling children in Head Start?

YES. There were dramatic (and highly significant) differences between the two groups not only in the overall proportion of children who entered Head Start but also in the margin of advantage that CFRP children had over controls.

2.3 Factors in Program Effectiveness

This section asks whether CFRP was more effective for some types of families than others. Two kinds of family characteristics were investigated: (1) Behavioral and psychological characteristics, specifically degree of program participation and level of "coping"; and (2) Background or demographic characteristics, such as ethnicity, employment, education, single-parent versus two-parent status. The former characteristics proved to be powerful mediators of CFRP's effects. Of the latter characteristics, only a few showed any relationship to program effectiveness.

Was CFRP more effective for active participants?

YES. Families who participated actively and/or remained in the program for relatively long periods showed the greatest changes in childrearing attitudes and practices, and feelings of efficacy. Active parents reported use of a wider range of community services and better access to preventive health services. They also were more likely than inactive ones to have obtained further education or job training.

Active participation or length of enrollment did not have a direct effect on children's social, cognitive or physical development. The few relationships that were found between intensity of treatment and child

outcomes were weak. Length of participation had a strong effect, however, on Head Start enrollment with a greater proportion of children entering Head Start from families who were still enrolled in CFRP at the end of the Infant-Toddler Component.

The above findings suggest that participation in CFRP activities was an essential ingredient in CFRP's success.

Was "coping" related to CFRP's effectiveness?

YES. Not only did the program improve parents' coping skills, but those who profited most from the program in other ways were those whose feelings of efficacy were strongest, either strong to begin with or becoming strong during the evaluation. We split the CFRP and control samples into groups who had high and low coping scores at the beginning of the study--before CFRP had any effects on its participants. Differences between the CFRP and control groups were consistently larger, for a wide range of outcome measures, among the "high copers." In addition, those parents who had high coping scores at the end of the study, regardless of their scores at the start of the study, were the ones who participated the most in the program and who also gained the most on other measures.

It should be noted that "high copers" were not all parents who were initially better off in economic and other circumstances. Many were people faced with severe financial and personal problems, but they were distinguished by an attitude of determination and confidence. Thus in stating that CFRP was most effective for "high copers" we are not claiming that it was effective only for easy cases.

Were other family characteristics related to CFRP's effectiveness?

YES. CFRP's positive effects on family circumstances--employment and/or enrollment in school or job training--were especially strong for single, black mothers with one child. This finding was due primarily to one

site, which served a large number of teenaged mothers. This CFRP was particularly effective in helping these mothers stay in school and find part-time work.

On the other hand, there were several groups of families who did not derive the full benefits from services offered in CFRP. CFRP on the whole did not seem to be well organized to serve working mothers. The working mother represented a real dilemma for CFRP. By going to work, a mother took a major step toward achieving financial independence. On the other hand, it was difficult to provide such mothers with services and pursue program goals, such as child development. Most program activities took place between nine to five, when working mothers could not participate. While efforts were made to accommodate mothers by scheduling home visits for the end of the working day, mothers and children were often too tired and distracted to get much out of the visits. Participation in center sessions was most problematic for these mothers. At most sites, families with working mothers participated in program activities at a significantly reduced rate or were effectively lost to the program.

CFRP also was not effective in serving a multicultural population. Cultural and class differences play an important role in parent education programs. Different sociocultural groups prefer different means of achieving their common goal of making children more successful academically, as well as having different ways of meeting other needs. Despite serious attempts on the part of some CFRPs to serve families of different ethnic backgrounds and to have racially mixed staffs, CFRP as a whole was not effective as a multicultural program. Families of the ethnic group that predominated in the local CFRP tended to stay in the program, while families of other ethnic backgrounds tended to drop out. Predominant race also affected participation in program activities--with families of other ethnic backgrounds tending to come less frequently to center sessions.

CHAPTER 3
POLICY IMPLICATIONS

The evaluation's findings have implications for program management, having to do with practices that contribute to the effectiveness of the CFRP approach as currently conceived. The findings also raise broader policy questions, about the basic assumptions underlying CFRP and the desirability of extending the CFRP approach as an option for all of Head Start. This chapter addresses both issues. Implications for program management are outlined in Section 3.1; policy questions are discussed in Section 3.2.

3.1 Implications for Program Management

In drawing implications from the evaluation findings, we are guided by the fact that CFRP was a demonstration program within Head Start. Its primary purpose has been to inform Head Start policy and national program management. Whatever the future of CFRP itself, its approach may be incorporated into Head Start guidelines and thereby affect local practices in Head Start and other child development programs.

The findings point to several recommendations for correcting flaws in CFRP's current mode of operations if the CFRP approach is adopted more widely within Head Start.

Establish detailed program guidelines for child development.

The natural evolution of local programs has not led to the balance between child development and other services that ACYF wanted and expected. According to informed sources in Head Start's national office, social services and child development were seen as mutually reinforcing, rather than competing activities when the CFRP Guidelines were written. A deliberate decision was

made not to impose a great deal of structure on local programs in the area of child development; it was assumed that the central importance of this goal would be recognized. The result, unfortunately, was some confusion and misperception on the part of local programs. The programs responded to the emphasis on social services that they saw as Washington's intent, and also responded to the clear need for social services in the populations they served. Many programs saw CFRP essentially as an expansion of Head Start's social services component and not as a child development program in itself. Families were typically recruited on the basis of their need for services and desire for psychological and social support--not their desire for parent education or for a program of developmental activities, though these may have been an added inducement.

To correct this misperception, CFRP's Guidelines must be strengthened in the area of child development. The relative emphasis to be placed on child development, parent education, personal counseling, crisis management and social service referrals must be spelled out, at least in broad terms. Programs should know what is expected of them, and where they are free to exercise their own judgment. Developmental goals should be spelled out, and evaluations should be linked to these goals so that programs do not feel they are being judged capriciously.

Provide guidelines for caseloads and home visit frequencies.

To reinforce the child development guidelines it is important that ACYF specify minimum frequencies of home visits and maximum caseloads for family workers. Drawing on the previous experience of Home Start, weekly visits appear to be necessary. The caseloads of 13 found to be workable in Home Start might have to be even lower, given the additional duties of the CFRP family worker in the area of social services. Reduction of caseloads entails either a reduction in the number of families served or an increase in staff costs--both admittedly unappealing options--or a reduction in other program costs. (One suggestion for cost reduction is provided below.)

Provide guidelines and resources for training and supervision.

Another step necessary to reinforce the increased emphasis on child development services is improved supervision and training of family workers, the key service providers in CFRP. Training and supervision are particularly important when programs recruit indigenous paraprofessionals for the job of family worker.

As a first step, guidelines are needed to tell local Head Start administrators what kind of staff training and supervision should be provided. To support programs in complying with these guidelines, ACYF will need to refocus its ongoing program of training and technical assistance. Materials should be provided to programs--for example, effective infant-toddler curricula that draw on the experiences of the more successful CFRPs and other early intervention programs. Local expert consultants could be used not only to train staff but also to provide continuous support to directors and staff. ACYF's program managers need to visit programs personally, to gather information and to oversee implementation of Washington's directives. Expansion of the program of the Home Start Training Centers to include training focused on children under three should also be explored.

Coordinate with Head Start and other agencies.

The findings suggest that local CFRPs that were closely tied to Head Start shared resources and provided greater continuity of experience for the child and family. If "CFRP" becomes a program option within Head Start, the problem of linkage between separate programs should not arise; however, program guidelines should give direction as to how resources may be shared between the "CFRP" portion of Head Start and the rest of the program, and how duplication of functions may be avoided, in order to maximize cost-effectiveness.

In addition, "networking" through referrals to other community agencies should be encouraged as another device for improving cost-effectiveness. National program managers can help by providing local Head Start

administrators with suggestions based on the experience of CFRP, which was generally more effective than Head Start in building relationships with local agencies.

Find ways to serve working mothers.

None of the five CFRPs studied intensively in the evaluation had developed particularly effective ways of serving working mothers. In the absence of successful models, our recommendation can only be that ACYF encourage local experimentation with services to working mothers, in an effort to develop successful practices that can later be disseminated.

3.2 Policy Questions

The recommendations above are all premised on the assumption that the CFRP approach might be adopted by Head Start in some form. However, broad policy issues currently being debated within ACYF call into question whether this will or should be done. The CFRP evaluation throws some light on these current issues, of which we have identified three in consultation with ACYF.

Continuity

A major thrust of ACYF policy for many years, and of CFRP itself, has been continuity of service through the early developmental period. This assumption is now being questioned, in part because of the cost of providing continuous services. Some have argued that a brief, intensive intervention at a carefully targeted age--at age four, just before entry into school--is a more cost-effective strategy.

The CFRP evaluation offers some evidence on the feasibility of mounting effective, home-based developmental interventions for infants and toddlers within the Head Start context. Although the research literature in child development contains examples of effective intervention programs for

parents of infants and toddlers, these programs involved highly trained staff and intensive work with parents and children. The CFRP evaluation suggests that less intensive intervention is ineffective. To produce measurable developmental gains in very young children requires a sustained, intensive and probably costly effort. Head Start has abundantly demonstrated its effectiveness for preschoolers. To offer Head Start services (other than family support and health services) to younger children, however, is not a simple extension of established practices but a major new undertaking.

Comprehensiveness

Another long-established tenet of ACYF policy is that developmental services are most effective when offered in the context of a full range of support services--health services, parent education and counseling, etc. This belief, too, was central to CFRP, and it, too, has been challenged. It has been argued that Head Start should be viewed as a program for educational preparedness, and that comprehensive services are costly frills.

The CFRP evaluation demonstrates clearly that support services can be provided to parents of infants and toddlers in the context of a home-based program--and that these services have far-reaching positive effects on families. However, the results also show that support services compete for staff time and program resources with other goals, especially child development. To abandon support services would be to abandon some of CFRP's--and Head Start's--most valued activities. To provide both support services and first-rate developmental services is a matter of staffing, training, planning, and ultimately of money.

Local Autonomy

A third new policy direction in ACYF and in the government generally is a thrust toward decentralization of control. In this CFRP actually anticipated current thinking by many years. CFRP deliberately allowed local programs a great deal of autonomy, expecting that local administrators and staff would design programs which were more responsive to local needs and resources than would be possible from Washington.

The results of that rather bold experiment in delegating authority are now in, and they are mixed. The 11 CFRPs did create service packages appropriate to their local populations. However, variations in practice from site to site went beyond the bounds consistent with ACYF's mandate and priorities, particularly in the area of child development. The results show both the advantages of inviting local initiative and ingenuity and the need to retain a measure of central control.

* * *

Only a few years ago a glowing report by the General Accounting Office held up CFRP and kindred programs as models for delivery of services to low-income families. At that time it might have been reasonable to contemplate a major new initiative within Head Start, based on CFRP and other demonstrations, which would offer comprehensive services to families and expand the age range of children served. In the present climate of fiscal austerity, and in light of the somewhat sobering results of the CFRP evaluation, it may be more appropriate to focus on the hard policy issues discussed above. It is our hope that this report has provided substantial information to inform debate on these issues.

APPENDIX A

ABT ASSOCIATES INC.
CFRP EVALUATION REPORTS*

Phase I

- Design Report (March 1979)--describes the overall study design and outcome domains.

- Study Implementation and Preliminary Baseline Profile (March 1979)--describes how the study was implemented and compares the entering characteristics of families who had been randomly assigned to a treatment or control/comparison group.

Phase II

- Research Report (February 1980)--documents the first six months of the study and examines initial program impact on families after six months in CFRP.

- Program Study Report (February 1980)--presents descriptive information about CFRP operations at the evaluation sites.

- Executive Summary (February 1980).

Phase III

- Program Study Report (November 1980)--presents descriptive profiles of all eleven CFRPs and a series of anecdotal "success stories" concerning the impact CFRP has had on six families and their children. The report also identifies models of certain aspects of CFRP operations that might be adapted or replicated in other communities that wish to provide family-oriented child development services.

- Infant-Toddler Component and Child Impact Report (December 1980)--describes program activities offered and examines the program's impact on the development of children approximately a year to a year and a half after they entered the program.

*Reports are available from the Administration for Children, Youth and Families or Abt Associates Inc. (at cost).

Phase III (continued)

- Research Report (March 1981)--examines CFRP's impact on families in outcome domains other than child development, after a year and a half of program participation, as well as the nature and extent of that participation.

- Executive Summary (March 1981).

Phase IV

- Analysis Issues and Measures Selection (June 1981)--outlines strategies to be used in answering research questions and a set of hypotheses concerning CFRP's impact on children and their families. The paper also makes recommendations concerning measures to be used in the concluding phase of the evaluation.

- The Culture of a Social Program: An Ethnographic Study of CFRP (Fall 1981) in two volumes (Main and Summary). The summary volume describes the design, methodology and implementation of a six-month qualitative study of CFRP, and summarizes results across sites. This volume also discusses various choices that programs must make in attempting to deliver a broad range of services with finite resources, outlining practical lessons that can be drawn from the CFRP demonstration and decisions that must be faced in designing any family-based child development program. Detailed case studies on each of the five CFRPs are presented in the Main Volume.

- The Effects of a Social Program: Final Report of CFRP's Infant-Toddler Component (Fall 1982)--describes program operations and examines CFRP's impact on families and children after three years of participation in the program.

APPENDIX B

EVALUATION DESIGN AND METHODS

The five-year evaluation of CFRP was initiated in 1977 by the Administration for Children, Youth and Families (ACYF) to provide detailed information about the effectiveness of this program as a whole, of individual programs, and of particular program elements or configurations of elements.* The initial design for the study consisted of three distinct but interrelated components--the program study, the impact study, and the process/treatment study. Together, they addressed the following four objectives:

- to describe CFRPs and their operations;
- to identify program models;
- to link family outcomes to participation and nonparticipation in CFRP; and
- to link family outcomes to particular aspects of the CFRP treatment and to family characteristics.

The three component studies were complementary ways of viewing the effects and effectiveness of CFRP. A brief description of the component studies and the measures and data collection procedures used follows.

The program study was designed to paint a comprehensive picture of the operations of CFRP. It established a descriptive context for the statistical and analytic findings of the study. Through three site visits and through interviews with CFRP staff and representatives of community agencies, descriptive profiles of program implementation were developed, and models of certain aspects or operations of the program were identified.

*The current evaluation was preceded by three other studies of CFRP, two of which were also funded by ACYF. The first, conducted by Huron Institute in 1974-75, was an effort to determine the feasibility of a summative evaluation of CFRP. A formative evaluation of CFRP was undertaken in 1974-75 by Development Associates Inc.; a follow-up study was conducted by the same contractor in 1975-77. The third study was carried out by the General Accounting Office (GAO), and its report was submitted to Congress in 1979.

The impact study examined the effects of CFRP services on low-income families and their children. A longitudinal, experimental design, involving random assignment to a treatment or control/comparison group was implemented at five sites.* At entry into the evaluation, there were an average of 40 CFRP and 42 control/comparison families per site, all with a child under one year old. The ethnic composition of the sample was as follows: 39 percent white, 47 percent black, 4 percent Hispanic, and 10 percent of other nonwhite or mixed ethnic backgrounds. The average age of mothers was 22 years; half of the mothers had completed high school and 12 percent had gone beyond high school. About one-fourth of the mothers were employed.

Fifty-nine percent of the infants (who were the focus of the study) were firstborn children. Slightly over one-fourth came from two-parent families; one-third of the mothers were single parents living with their extended families. Welfare was the primary source of income for two out of five families.

Attrition over the three-year data collection period reduced the sample by 38 percent. Somewhat different types of families dropped out of the CFRP and control/comparison groups. The groups, which were virtually equivalent at the beginning of the study, were no longer equivalent at the end when most outcome measures were taken. A variety of statistical adjustments were needed to compensate for the non-equivalence of the two groups. Attrition also weakened the evaluation's capacity to detect program effects within subgroups of families and single sites. However, statistical power for comparisons involving the sample as a whole was not affected catastrophically by sample attrition.

The impact study focused on five outcome domains. The domains and measures used to assess CFRP effects are briefly described below.

*The five sites were: Jackson, MI; Las Vegas, NV; Oklahoma City, OK; St. Petersburg, FL;, and Salem, OR. Sites were selected on the basis of their ability to recruit the requisite number of families, not as a representative sample of the 11 CFRPs.

- Child Development and Achievement. CFRP's impact was assessed at two time points: after 18 months and after three years, which marked the conclusion of the Infant-Toddler Component. Measures included:

  - Bayley Scales of Infant Development (after 18 months), which examines children's mental and physical development.

  - Preschool Inventory (32 items), a general measure of children's achievement in areas often regarded as necessary for success in school (after 3 years).

  - High/Scope Pupil Observation Checklist (after 3 years), a tester rating scale which assesses child test orientation and sociability.

  - Schaefer Behavior Inventory (after 3 years), a parent rating scale of child behavior which assesses task orientation, introversion-extroversion, and hostility-tolerance.

- Parent Teaching Skills. CFRP's impact was assessed twice (after 18 months and 3 years), using the following measures:

  - Carew Toddler and Infant Experiences System (TIES), an in-home observation system focusing on the child's interactions with the physical and social environment, particularly the mother. The study involved a subset of families in two sites (after 18 months).

  - Strom's Parent-As-A-Teacher Inventory (PAAT) assessed parent teaching skills through self report after 3 years. The measure consists of 50 statements concerning parent-child relations. Information is obtained in five areas: encouragement/discouragement of creativity, frustration about childrearing, control and how it is achieved, play and its developmental functions, and the teaching-learning process.

- Maternal and Child Health data were obtained at various time points. Data included birth records, information about birth circumstances, height and weight measures, and data about preventive health care--medical and dental checkups for mother and child, health insurance, and problems obtaining health care services.

- Family Functioning. Two aspects of family functioning were assessed at various time points:

  - independence in arranging for social services
  - locus of control and coping strategies using a five-item locus of control scale.

- Family Circumstances. Data were collected at each data collection point, including: mother's employment, enrollment in school or job training, income sources and use of community resources.

In addition, data were obtained about the transition of children from CFRP's Infant-Toddler Component to Head Start.

The process/treatment study was designed to determine how program impact was affected by family characteristics, staff characteristics, specific types of interactions between families and staff, and specific services provided to families. Detailed information was gathered about family participation in program activities over the three-year data collection period. Relationships among family characteristics, participation and program effectiveness were explored via statistical techniques.

A fourth component--the ethnographic study--was added in fall 1980 because important aspects of the program's relationship to families were not being captured. The six-month study was designed to find out, through qualitative methods, how the program was experienced by families and why the program produced or failed to produce the desired effects. The study involved from seven to nine families at each of the five sites, and employed a variety of data collection strategies.

Data for the CFRP evaluation were collected at six time points starting in fall 1978 (pretest) and ending in fall 1981, at the time the children moved from the Infant-Toddler Component into Head Start.

Analytic Approach

Our approach to assessing CFRP's effects involved several elements. We began by looking for overall program effects on each outcome measure, i.e. for statistically significant differences between CFRP and the control/comparison groups, after adjustment for nonequivalence of the two groups (due to attrition). Analyses involved the whole sample and were performed in several ways to ensure that results were stable in the face of technical variations.

Simple, overall comparisons were important but not enough. Dramatic variations from site to site in program approaches (see Chapter 1) and populations served made it necessary to pay careful attention to site to site differences in outcomes. We looked for evidence of such differences in the magnitude of program effects (program-by-site interactions). In addition we conducted within-site analyses, paying particular attention to the direction and magnitude, rather than conventional significance, of effects.

Individualization of services within sites made it necessary to examine patterns of outcomes for different types of families. The sample was partitioned in a variety of ways to determine whether CFRP had different effects for different types of families with potentially different patterns of needs. Specifically, we compared effects (treatment-control differences) for firstborn children versus children with older siblings, families headed by single women versus two-parent families, families in which the mother had graduated from high school versus those in which she had not, and black versus white families. In addition we compared effects for children who had experience in day care versus those who had not based on the assumption that control children in day care may have received services paralleling those of CFRP. Finally, we compared effects for mothers who showed different patterns on an attitudinal variable--"coping," or locus of control.

Wide variation in levels of participation made it necessary to look for differences in outcomes that might be linked to participation rates. Two approaches were taken to determine whether the program conveyed more benefits

when "treatment" was actually received. Within the CFRP group, we related outcomes to several different measures of treatment. Second, we compared all outcomes for the subset of CFRP families who were moderate-to-high participants versus the (entire) control group.

Supplementing all of the above quantitative analyses, we searched for corroborating or disconfirming evidence in the qualitative data provided by the program study and especially the ethnographic study. These qualitative data gave insights into the reasons for observed patterns of effects.

APPENDIX C

ACKNOWLEDGMENTS

This five-year study could not have been completed without the cooperation and assistance of numerous persons and groups. Several of these deserve special recognition for their contributions to the evaluation effort.

We are especially grateful to Dr. Esther Kresh, the ACYF Project Officer for this evaluation, for her continuing guidance, assistance, and support. At several time points in the evaluation, she played a central role in helping us address complex methodological issues and redirect the focus of the study. We also want to express our appreciation to other ACYF officials for their interest, enthusiasm, and guidance--Ms. Martella Pollard, Program Manager of the CFRP Demonstration; Dr. Ray Collins, Director of the Office of Program Development; and Dr. (Ruth) Ann O'Keefe, former Director of the CFRP Demonstration who continued to serve as an ad hoc member of the National Advisory Panel after joining the Navy Family Program.

We wish to acknowledge the valuable assistance the directors and staff at the CFRP study sites have provided in the evaluation effort. They gave generously of their time, completing records and responding to questions about the operations of their program and services delivered to families. Special thanks go to the families in the CFRP treatment and control/comparison group for making themselves available to our staff for interviews and observations during the three-year data collection period. Together, they provided invaluable insights into what it means to participate in CFRP and the challenges that program staff face. We also wish to extend our appreciation to the CFRP sites that were not selected for the study but contributed to reports describing the operations of the CFRP demonstration.

The National Advisory Panel provided the staff with guidance, assistance, and support from the start of this five-year undertaking. Several panel members deserve special recognition for their contributions to the study: Ms. Kathryn Hewett, project director of the CFRP evaluation during the first two years. She was responsible for study design and imple-

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Marrit J. Nauta
Project Director
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